

Physicians Plus wants to make sure that your claims are processed quickly and accurately, especially when you're covered by more than one health or prescription drug insurance plan. Your P+ policy includes a "coordination of benefits" provision that outlines claim processing guidelines in such cases. **Please complete this form to help ensure that your future insurance claims are processed correctly and without delay. Failure to respond may delay claim payments. If you have completed this form before, and none of your insurance information has changed, you do not need to fill the form out again.**

Coordination of benefits determines which plan is responsible for paying a claim first (primary) and which plan pays second (secondary). A detailed description is available in your Medical Certificate of Coverage or the "It's Your Choice" booklet (if you are a State of Wisconsin or Wisconsin Public Employee member).

Thank you for helping us gather this information. If you have any questions, please call Member Service at (608) 282-8900 or (800) 545-5015.

Physicians Plus Policy Holder Name: _____ **Birth Date:** _____

Member Number: _____ **E-mail Address:** _____

Other Insurance Information If you need more space to answer any question, please attach an additional sheet of paper.

1. Are you or any other family member (on this plan) covered by this Physicians Plus plan and another health insurance policy (e.g., major medical plan, Medicare, student health plan, indemnity plan, PPO, POS or HMO)?

If **yes**, please complete the form and return it to Physicians Plus as instructed below.

If **no**, you can disregard this form.

2. Please list the other health insurance policies covering you and/or your family.

Policy Type (Medicare, POS, etc.): _____ Name of Insurance Carrier: _____

Policy Member Number: _____ Effective Date: _____

Name of Policy Holder: _____ Phone Number of Policy: _____

Persons Covered by the Policy: _____

Does this policy include coverage for prescription drugs (circle one)? Yes No

3. Do you have a separate insurance policy (other than listed above; including Medicare Part D) that covers prescription drugs (circle one)? Yes No

If yes, please complete the information below.

Name of Prescription Drug Policy: _____

Member Number on Policy: _____ Effective Date: _____

4. Do you or any other family member (on this policy) have coverage under Medicare (circle one)? Yes No

If yes, please complete the information below for each person with Medicare coverage:

Name: _____ Name: _____

Medicare Number: _____ Medicare Number: _____

Coverage (circle all that apply): _____ Coverage (circle all that apply): _____

Part A Part B Part C Part D Part A Part B Part C Part D

Effective Date: _____ Effective Date: _____

Reason for Medicare coverage (circle one): _____ Reason for Medicare coverage (circle one): _____

Over age 65 Disability End-Stage Renal Disease (ESRD) Over age 65 Disability End-Stage Renal Disease (ESRD)

5. If you have dependent children on this health plan whose health insurance coverage is paid by another person due to divorce, court order or custody agreement, please complete the following:

Name of person responsible for insurance coverage: _____

Type of custodial arrangement (circle one): Full Joint

If full, name of custodian: _____ Effective Date with Other Insurance Plan: _____

Name of Child(ren): _____



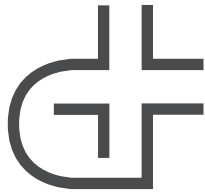
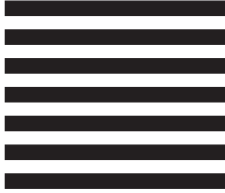
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Thank you for completing this form.